Long Term Care Program Options
For Wisconsin's Elderly and Disabled Adults

March 2006

1. ***Program Description***	Full Program Name	State Statutory Authority	Target Population	Entitle-ment (Y/N)?	Statewide or Demo Site(s)?	Consumer Entry Point(s)	Program Summary
Non-institutional Medicaid (Medicaid Fee-for-Service or Card Services	Medicaid Fee-for-Service Benefits	S. 49.46	Elderly (65 or older); Blind or Disabled.	Yes	Statewide	For enrollment: County Human Service Departments, County Outreach Centers, tribal agencies, Aging and Disability Resource Centers where available, or automatic coverage for anyone who receives cash assistance under SSI.Services are provided by Medicaid-certified providers.	Medicaid covers medically necessary acute and long-term care services. Federal regulations define the specific services provided. Beyond the federally required services, Wisconsin covers "optional" services allowed by federal law. Wisconsin Medicaid service coverage is extensive.
PACE & Partnership	Program for All Inclusive Care for the Elderly. Wisconsin Partnership Program.	PACE is offered as a "state plan" service.	PACE: Frail Elderly (age 55+). Partnership: Frail Elderly (age 55+) / Adults with physical disabilities.	No	PACE: Milwaukee. Partnership: Milwaukee, Racine, Dane, Eau Claire, Chippewa, Dunn.	Private, non-profit agencies	Integrated Medicaid, Medicare funded programs designed to maximize the ability of target populations to remain in the community. Primary, acute and long-term care (LTC) is planned/managed by inter-disciplinary teams that include medical & social service professionals. Contractors receive a per member per month payment and assume full risk. Participants in Partnership must be Medicaid eligible and may also be Medicare eligible. Milwaukee's PACE provider became permanent in 2003. Participants may be Medicaid, Medicare or dually eligible for both Medicaid and Medicare.
COP	Community Options Program	s. 46.27	Frail elderly; persons w/ physical disabilities, severe & chronic mental illness, developmental disabilities, or with alcohol or drug abuse problems.	No	Statewide, except that in Family Care counties COP is used only for children, chronically mentally ill and alcohol & other drug abuse.	DSS, DHS, DCP or sub-contractor	A 100% state GPR funded program designed to provide LTC assessments, care plans and community services as an alternative to NH placement. Need not be Medicaid eligible.
COP-W	Community Options Program-Waiver	s. 46.27 (11)	Frail elderly; physically disabled adults	No	Statewide, except Family Care counties	DSS, DHS, DCP or sub-contractor or Dept. of Aging	A Medicaid-funded (state and federal) program designed to provide community services as an alternative to NH placement. Participants must be Medicaid eligible.
CIP-1A	Community Integration Program-1A	s. 46.275	Developmentally disabled of any age, who reside or would enter a State Center without this program.	No	Statewide.	DCP or DHS	A Medicaid-funded (state and federal) program designed to provide community services to persons who are relocated or diverted from the DD Centers. Participants must be Medicaid eligible.
CIP-1B	Community Integration Program-1B	s. 46.278	Developmentally disabled, of any age, who are diverted or relocated from non-Center Intermediate Care Facility for Mental Retardation & certain nursing home beds.	No	Statewide.	DCP or DHS	A Medicaid-funded (state and federal) program designed to provide LTC assessments, care plans and community services to persons who are relocated or diverted from ICFs-MR other than the DD Centers. Participants must be Medicaid eligible.
CIP-II	Community Integration Program II	s. 46.277	Frail Elderly; Physically disabled adults	No	Statewide, except Family Care Counties	DSS, DHS, DCP or subcontractor, Dept. of Aging	A Medicaid-funded (state and federal) program designed to provide community services as an alternative to elderly and physically disabled persons. Funding for available placements is based on NH beds that have closed and are de-licensed. Participants must be Medicaid eligible.

1. Program Description, cont'd	Full Program Name	State Statutory Authority	Target Population	Entitle-ment (Y/N)?	Statewide or Demo Site(s)?	Consumer Entry Point(s)	Program Summary
BI Waiver	Brain Injury Waiver	s. 46.278 s. 51.01 (2g)	Adults and Children who meet the definition of brain injury in s.51.01 (2g)(a) and are diverted/relocated from NH or hospital units designated for brain injury rehabilitation.	No	Statewide	DCP or DHS	A Medicaid funded (state and federal) program designed to provide home and community based services for people with brain injuries who need significant supports.
Family Care (Medicaid)	Family Care	s. 46.2805 and s. 46.2895	Frail elderly; physically and developmentally disabled: age 18 or older.	Yes	Available in Fond du Lac, La Crosse, Portage and Richland counties (for Milwaukee county, see Milwaukee 's chart).	Resource Center	A Medicaid funded (state and federal) program designed to provide LTC assessments, care plans and services (community and institutional-based) to functionally and financially eligible disabled adults and elderly persons. Organizations receive a per member, per month payment to provide long-term care and some health related services.
Institutional Medicaid	Institutional Medicaid	s. 49.498	Frail elderly; physically and developmentally disabled with significant needs that cannot be addressed in a home setting.	Yes	Statewide	DSS, DHS	Medicaid-funded benefits for people residing in medical institutions (nursing homes, hospitals, etc.) for 30 days or more. Coverage is limited to persons age 65 and over, or disabled, with significant long term care needs. Benefits include acute, primary and long-term care services.
SSI-Managed Care	SSI-Managed Care	HFS 107.28	Elderly (65 or older); Blind or Disabled.	No.	Milwaukee County in April 2005. Dane, Racine, Kenosha and Waukesha counties scheduled for implement-ation in May 2006.	Automated Health Systems Enrollment Broker.	Care coordinators and a provider network coordinate medical and social services for SSI disabled Medicaid recipients. Care coordinators serve in a gatekeeper role. Goals include improving care quality and access. Contractors receive a per member per month payment. Participants must be Medicaid eligible.

2. Administration	Local	State	Federal
Non-institutional Medicaid (Medicaid Fee-for-Service or Card Services	County Human services and tribal agencies provide eligibility determination under State direction. Medicaid coverage is automatic for anyone who receives cash assistance under SSI. LTC benefits are provided by local providers.	*DHCF	*CMS (formerly HCFA)
PACE & Partnership	PACE -Community Care Organizations (CCO). Partnership – Community Care Health Plan (CCHP)	* DDES	CMS
COP	COP Lead or Joint Leads; DHS, DSS, 51 Board, or County Aging; Oneida Tribe	DDES BLTS*	None
COP-W	DHS, DSS, 51 Board, Joint Lead or County Aging; Oneida Tribe	DDES BLTS	CMS
CIP-1A	51, 42/437 Boards, DHS	DDES BLTS	CMS
CIP-1B	51, 42/437 Boards, DHS	DDES BLTS	CMS
CIP-II	DHS, DSS, 51 Board, Joint Lead, or County Aging; Oneida Tribe	DDES BLTS	CMS
BI Waiver	51, 42/437 Boards, DHS	DDES BLTS	CMS
Family Care (Medicaid)	Resource Centers & Care Management Organizations	DDES	CMS
Family Care Non-MA (Currently frozen)	Resource Centers & Care Management Organizations	DDES	CMS
Institutional MA	Private For-Profit, Private Non-Profit and Government	DHCF	CMS
SSI-Managed Care	Private For-Profit	DHCF	CMS

* CMS = Centers for Medicaid and Medicare Services
* DHCF = Division of Health Care Financing
* DDES = Division of Disability and Elder Services
* BLTS = Bureau of Long Term Support

3. Funding & Reimbursement	Primary Funding Source	Secondary Funding Source(s)	Fee-for-Service or Capitated Rate	Can Recipient of Services under this Program receive LTC Funded through other programs listed here?
Non-Institutional Medicaid (Medicaid Fee-for-Service or Card Services)	Approximately 60% Federal funding. Approximately 40% State funding.	Medicaid coordinates benefits with private health insurance and Medicare, since Medicaid is secondary to those payers.	Fee-for-service	Yes. Recipients may receive fee-for-service Medicaid benefits and also participate in the HBC waivers. The waivers "wrap around" Medicaid services. Recipients cannot receive fee-for-service benefits if enrolled in a managed care initiative, such as Family Care and Partnership.
PACE & Partnership	Medicaid Medicare	Exhausted	Capitated	No.
COP	State General Purpose Revenue	Medicaid (pays at 60% of the cost of assessment care plans and for care management for Medicaid eligibles on COP.)	Fee-for-service	Yes. Recipients of COP funded services may participate in COP-W, CIP-1A, CIP-1B, CIP II, or BI Waiver. COP funds are sometimes used to supplement funding associated with these Medicaid HCBW waiver programs.

3. Funding & Reimbursement, Cont'd	Primary Funding Source	Secondary Funding Source(s)	Fee-for-Service or Capitated Rate	Can Recipient of Services under this Program receive LTC Funded through other programs listed here?
COP-W	Medicaid	For costs above the state/federal per diem, counties may contribute 40% (community aids, COP or local taxes) to access additional 60% federal match	Fee-for-service Per diem	Yes. Local administrative agency may combine COP-W funds with COP funds to provide needed care; agencies may not combine COP-W funds with any of the other program funding sources listed here. Further, agencies may not use MA Case Mgmt. funds to enhance a person's COP-W funded services.
CIP-1A	Medicaid	For costs above the state/federal per diem, counties may contribute 40% (community aids, COP or local taxes) to access additional 60% federal match.	Fee-for-service Per diem	Yes. Local administrative agency may combine CIP-1A funds with COP funds to provide needed care; agencies may not combine CIP-1A funds with any of the other waiver program funding sources listed here. Further, agencies may not use MA Case Mgmt funds to enhance a person's CIP 1A funded services.
CIP-1B	Medicaid	For costs above the state/federal per diem, counties may contribute 40% (community aids, COP or local taxes) to access additional 60% federal match.	Fee-for-service Per diem	Yes. Local administrative agency may combine CIP-1B funds with COP funds to provide needed care; agencies may not, however, combine CIP-1B funds with any of the other waiver program funding sources listed here. Further, agencies may not use MA Case Mgmt funds to enhance a person's CIP 1B funded services.
CIP-II	Medicaid	For costs above the state/federal per diem, counties may contribute 40% (community aids, COP or local taxes) to access additional 60% federal match	Fee-for-service Per diem	Yes. Local administrative agency may combine CIP-II funds with COP funds to provide needed care; agencies may not, however, combine CIP-II funds with any of the other waiver program funding sources listed here. Further, agencies may not use MA Case Mgmt funds to enhance a person's CIP II funded services.
BI Waiver	Medicaid	For costs above the state/federal per diem, counties may contribute 40% (community aids, COP or local taxes) to access additional 60% federal match	Fee-for-service	Yes. Local administrative agency may combine BIW funds with COP funds to provide needed care; agencies may not, however, combine BIW funds with any of the other waiver program funding sources listed here. Further, agencies may not use MA Case Mgmt funds to enhance a person's BIW funded services.
Family Care (Medicaid)	Medicaid		Capitated	Medicaid eligibility can be through MAPP or BadgerCare as long as person is in Family Care target group and is functionally eligible.
Institutional MA	Medicaid	None.	Fee-for-service	No.
SSI-Managed Care	Medicaid Medicare	Contracted Managed Care Organizations	Capitated	Enrollment in one of several contracted managed care organizations.

4. Eligibility	Non-financial eligibility	Functional eligibility	Cost sharing?	Spend down?	Asset Limit	State Approval of care plan required?
Non-Institutional Medicaid (Fee-for-Service or card services).	Yes, based on federal requirements.	Not for overall eligibility or delivery of most services. All services must be medically necessary.	Medicaid co-payments on most, but not all services. Co-pays do not apply to children under 18 years of age.	For people who do not currently meet the financial eligibility requirements, Medicaid has a deductible determined on a six-month basis. Potential eligibles can meet the deductible through prepay, incurring medical expenses or having unpaid medical bills not previously used to meet a Medicaid deductible.	There is no asset limit for "family Medicaid." SSI-related Medicaid has an asset limit of $2,000 for a single person and $3,000 for a couple.	Not for overall eligibility or delivery of some services. Some services require prior authorization that includes review of the plan of care.
PACE & Partnership	Medicaid non-financial eligibility	Long-term care Functional Eligibility.	Yes, if monthly income minus deductions is above $783, but at or below $ 1,809.	Yes, if gross monthly income is greater than $1,809 and gross monthly income minus the following monthly expenses or minus the cap is less than or equal to $591.67: • Work related expenses • Health insurance premiums, and • Medical remedial expenses (including cost of waiver services)	$2000. If spousal impoverishment protections apply, community spouse asset share: $99,540 maximum (plus $2000).	No.
COP	Medicaid non-financial eligibility. 180 day residency requirement.	Long-Term Care Functional Screen. COP Level 3 Eligibility.	Yes, if monthly combined resources (a combination of income and assets) exceed monthly allowances. The minimum monthly allowance for a COP participant who does not reside in substitute care is $3,000.	No.	Resources (the combination of income and assets) cannot exceed $34,120 over a six-month period. When spousal impoverishment protections apply, add the community spouse asset allowance to the $34,120 amount.	No.

4. Eligibility, Cont'd	Non-financial eligibility	Functional eligibility	Cost sharing?	Spend down?	Asset Limit	State Approval of care plan required?
COP-W and CIP-II	Medicaid non-financial eligibility—except for 180 day residency requirement	Long-term Care Functional Screen, Nursing Home Level of Care: -Intensive Skilled Nursing. -Skilled Nursing Facility. -Intermediate Care Facility.	Yes, if monthly income minus deductions is above $783 but at or below $1,809.	Yes, if gross monthly income is greater than $1,809 and gross monthly income minus the following monthly expenses is less than or equal to $591.67: • Work related expenses • Health insurance premiums, and • Medical remedial expenses (including cost of waiver services)	$2000. If spousal impoverishment protections apply, community spouse asset share: $99,540 maximum (plus $2000).	Yes
CIP-1A	Medicaid non-financial eligibility	LTC-FS Eligibility DD-1, 2 or 3	Yes, if monthly income minus deductions is above $783, but at or below $1,809.	Yes, if gross monthly income is greater than $1,809 and gross monthly income minus the following monthly expenses is less than or equal to $591.67: • Work related expenses • Health insurance premiums, and • Medical remedial expenses (including cost of waiver services)	$2000. If spousal impoverishment protections apply, community spouse asset share: $99,540 maximum (plus $2000).	Yes.
CIP-1B	Medicaid non-financial eligibility	LTC-FS Eligibility DD-1, 2 or 3	Yes, if monthly income minus deductions is above $783, but at or below $1,809.	Yes, if gross monthly income is greater than $1,809 and gross monthly income minus the following monthly expenses is less or equal to $591.67: • Work related expenses • Health insurance premiums, and • Medical remedial expenses (including cost of waiver services)	$2000. If spousal impoverishment protections apply, community spouse asset share: $99,540 maximum (plus $2000).	Yes.
BI Waiver	Medicaid non-financial eligibility	Level of care as determined by BLTS	Yes, if monthly income minus deductions is above $783, but at or below $ 1,809.	Yes, if gross monthly income is greater than $1,809 and gross monthly income minus the following monthly expenses is less than or equal to $591.67: • Work related expenses • Health insurance premiums, and • Medical remedial expenses (including cost of waiver services)	$2000. If spousal impoverishment protections apply, community spouse asset share: $99,540 maximum (plus $2000).	Yes
Family Care (Medicaid)	Medicaid non-financial eligibility	Determined by the long-term care functional screen; Nursing Home LOC; Comprehensive, Intermediate	Yes, if monthly income minus deductions is above $783, but at or below $ 1,809.	Yes, if gross monthly income is greater than $1,809 and gross monthly income minus the following monthly expenses or minus the cap. Is less than or equal to $591.67: • Work related expenses • Health insurance premiums, and • Medical remedial expenses (including cost of waiver services)	$2000. If spousal impoverishment protections apply, community spouse asset share: $99,540 maximum (plus $2000).	No.
Institutional MA	Medicaid non-financial eligibility	Level of Care = Developmentally Disabled-1,2, or 3; Intermediate Care Facility 1,2; or Skilled Nursing or Intensive Skilled Nursing as determined by the Bureau of Quality Assurance.	Yes, after allowance for certain expenses, e.g. health insurance premiums, support obligation, personal needs allowance, etc.	No.	$2000. If spousal impoverishment protections apply, community spouse asset share: $99,540 maximum (plus $2000).	No.
SSI-Managed Care	Medicaid non-financial eligibility	No. If NH level of care, should not enroll in SSI - Managed Care.	No.	No.	SSI-related Medicaid has an asset limit of $2,000 for a single person and $3,000 for a couple.	No.

5. Allowable Services and Living Arrangements	Allowable Services	Allowable Living Arrangements
Non-Institutional Medicaid (Fee-for-service or card services)	All Medicaid acute and primary care services. The long term care services that are covered by Family Care benefit package are not covered under the card for Family Care enrollees.	Enrollment to Medicaid services is not dependent on living arrangement. However, some services are not separately reimbursed if the service is included in an institutional rate.
PACE and Partnership	Comprehensive Medicaid, Medicare and HCBW	All, within operation under protocol.

5. Allowable Services and Living Arrangements	Allowable Services	Allowable Living Arrangements
COP	Any services, equipment, or adaptive aid the person needs to remain safely in the community including assessment, care planning and care management, substitute care (including room and board). Counties may limit scope of service coverage with COP funds.	-Natural residential settings -Adult Family Homes (licensed or certified) -CBRFs consisting entirely of independent apartments -Community Based Residential Facilities (CBRFs) up to 20 beds; over 20 beds with a variance.
COP-W	Card services except Medicaid case management (which is covered by the waiver). Approved waiver services include: -Care Management -Service Coordination -Supportive Home Care -General & Institutional Respite Care -Daily Living Skills Training -Residential Care (excludes room & board) -Personal Emergency Response System -Financial Management Services -Communication Aids, Interpreter Services & Adaptive Equipment -Medical Supplies -Employment Services (excludes job coaching and sheltered workshops) -Housing Costs for Nursing Home Relocations -Day Services -Adult Day Care -Housing Modifications -Transportation -Home Delivered Meals -Counseling & Therapy Services -Nursing Services -Personal Care	-Natural residential settings. -Adult Family Homes (licensed or certified) -CBRFs consisting entirely of independent apartments -CBRFs up to 20 beds; over 20 beds with a variance. -Certified RCACs.
CIP-1A	Card services except case mgt. (which is covered by the waiver). Services specified in approved waiver include: -Adult Day Care -Respite Care -Institutional Respite -Supportive Home Care -Day Services—Case Management/Service Coordination -Pre-Vocational Services -Daily Living Skills Training -Personal Emergency Response System -Counseling & Therapeutic Services -Supported Employment (excludes supported employment & pre-vocational services for diverted persons) -Community Aids -Home Modification -Adult Family Home -Adaptive Aids -CBRF -Children's Foster Home -Transportation	-Natural residential settings. -Community based substitute care up to 4 beds (with waivers, up to 8 beds for adults)
CIP-1B	Same as CIP-1A.	-Natural residential settings. -Community based substitute care up to 4 beds (with waivers, up to 8beds for adults)
CIP-II	Same as COP-W	-Natural residential settings. -Adult Family Homes (licensed or certified) -CBRFs consisting entirely of independent apartments -CBRFs up to 20 beds; over 20 beds with a variance. -Certified RCACs.
BI Waiver	Card services except case management (which is covered by the waiver). Services specified in the approved waiver include: -Case Management -Supportive Home Care -Respite Care -Adult Day Care -Prevocational Services -Home Modification -Personal Emergency Response System—Communication Aids -Counseling & Therapeutic Resources -Alternate Living Arrangements (Adult Family Home, CBRF, Children's Foster Home) -Daily Living Skills Training -Day Services -Transportation -Institutional Respite -Supported Employment -Adaptive Aids	-Natural residential settings -Community based substitute care up to 4 beds (with waivers up to 8 beds for adults).
Family Care	The Family Care benefit package includes all services available in the Medicaid Home and Community Based Waivers and Medicaid nursing home and long-term care "card" services such as home health and personal care. In addition, Family Care CMOs can opt to provide other services if they are effective in achieving members' outcomes. See Long Term Options in Fond du Lac, La Crosse, Portage and Richland, Section 5, for a listing of the Family Care Benefit Package and also: http://dhfs.wisconsin.gov/Medicaid2/handbooks/familycare/appendix4.htm	-Natural residential settings -CBRFs: there are no size limits for elderly and persons with physical disabilities. Developmentally disabled adults may be served in CBRFs of 4 beds or less (up to 8 with a variance). -Certified RCACs -Nursing Homes, Extended care facilities
Institutional Medicaid	All Medicaid covered services.	-Nursing Homes -Intermediate Care Facilities for the Developmentally Disabled (ICF/MR) -Hospitals
SSI-Managed Care	All Medicaid covered services, except Targeted Case Management, chiropractor, Family Planning, CSP, and Crisis Intervention.	-Natural residential settings; up to 90 days in NH.